General

Guideline Title

Endometrial ablation.

Bibliographic Source(s)

American College of Obstetricians and Gynecologists (ACOG). Endometrial ablation. Washington (DC): American College of Obstetricians and Gynecologists (ACOG); 2007 May. 16 p. (ACOG practice bulletin; no. 81). [79 references]

Guideline Status

This is the current release of the guideline.

The American College of Obstetricians and Gynecologists (ACOG) reaffirmed the currency of this guideline in 2012.

Recommendations

Major Recommendations

The grades of evidence (I-III) and levels of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

The following recommendations and conclusions are based on good and consistent scientific evidence (Level A):

For women with normal endometrial cavities, resectoscopic endometrial ablation and nonresectoscopic endometrial ablation systems appear to be equivalent with respect to successful reduction in menstrual flow and patient satisfaction at 1 year following index surgery.
Resectoscopic endometrial ablation is associated with a high degree of patient satisfaction but not as high as hysterectomy.

The following recommendations and conclusions are based on limited or inconsistent scientific evidence (Level B):

Hysterectomy rates associated with both resectoscopic endometrial ablation and nonresectoscopic endometrial ablation are at least 24% within 4 years following the procedure.
Women undergoing endometrial ablation with previous or concomitant laparoscopic sterilization are at low risk for the development of cyclic or intermittent pelvic pain subsequent to the procedure.
Patient satisfaction and reduction in menstrual blood flow after endometrial ablation in women with normal endometrial cavities is similar to that experienced by women using the levonorgestrel-secreting intrauterine system.

The following recommendations and conclusions are based primarily on consensus and expert opinion (Level C):

Patients who choose endometrial ablation should be willing to accept normalization of menstrual flow, not necessarily amenorrhea, as an

outcome.
Premenopausal patients undergoing endometrial ablation should be counseled to use appropriate contraception.
Nonresectoscope endometrial ablation is not recommended in women with endometrial cavities that exceed device limitations.
The endometrium of all candidates for endometrial ablation should be sampled, and histopathologic results should be reviewed before the procedure.
Women with endometrial hyperplasia or uterine cancer should not undergo endometrial ablation.
Performance of nonresectoscopic endometrial ablation in patients with prior classic cesarean delivery or transmural myomectomy may increase the risk of damage to surrounding structures. If endometrial ablation is to be performed in such patients, it may be best to perform resectoscopic endometrial ablation with laparoscopic monitoring. Safety of nonresectoscopic endometrial ablation in women with low transverse cesarean delivery has not been adequately studied.
For resectoscopic endometrial ablation, it is recommended that a fluid management and monitoring system that provides "real-time" output of fluid balance be used.

Definitions:

Grades of Evidence

I Evidence obtained from at least one properly designed randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Levels of Recommendation

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Abnormal uterine bleeding (menorrhagia)

Guideline Category

Evaluation

Treatment

Clinical Specialty

Obstetrics and Gynecology

Surgery

Intended Users

Physicians

Guideline Objective(s)

To aid practitioners in making decisions about appropriate obstetric and gynecologic care
To review the efficacy, safety, indications, and limitations of techniques for endometrial ablation

Target Population

Pre- or postmenopausal women with abnormal uterine bleeding

Interventions and Practices Considered

Surgical Endometrial Ablation

- Laser and resectoscopic endometrial ablation
- Nonresectoscopic endometrial ablation
  - Cryotherapy
  - Heated free fluid
  - Microwaves
  - Radiofrequency electricity
  - Thermal balloon
- Endometrial sampling and review of endometrial histopathological results before surgery
- Counseling of women to use contraception following endometrial ablation
- Performance of resectoscopic endometrial ablation with laparoscopic monitoring
- Use of fluid management and monitoring system during resectoscopic endometrial ablation
- Anesthesia use during endometrial ablation
- Endometrial ablation in the presence of uterine leiomyomata

Major Outcomes Considered

- Patient satisfaction
- Bleeding outcome
- Rates of complications
- Rates of repeated procedures and hysterectomies
- Duration of hospitalization

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

2007 Guideline

The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 1985 and October 2006. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles.

2012 Reaffirmation

Medline/Pubmed/Cochrane databases were searched for literature published from 2007-2012.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

I Evidence obtained from at least one properly designed randomized controlled trial.

II-1 Evidence obtained from well-designed controlled trials without randomization.

II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Methods Used to Analyze the Evidence

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

2007 Guideline

Analysis of available evidence was given priority in formulating recommendations. When reliable research was not available, expert opinions from obstetrician–gynecologists were used. See also the "Rating Scheme for the Strength of Recommendations" field regarding Grade C recommendations.

2012 Reaffirmation

A committee member reviewed the document and new literature search on the topic. The document was then reviewed by the committee and the committee agreed that it is current and accurate.

Rating Scheme for the Strength of the Recommendations

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A — Recommendations are based on good and consistent scientific evidence.

Level B — Recommendations are based on limited or inconsistent scientific evidence.

Level C — Recommendations are based primarily on consensus and expert opinion.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

Practice Bulletins are validated by two internal clinical review panels composed of practicing obstetrician-gynecologists generalists and sub-specialists. The final guidelines are also reviewed and approved by the American College of Obstetricians and Gynecologists (ACOG) Executive Board.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of endometrial ablation

Potential Harms

Fluid overload (resectoscopic only)

Electrolyte disturbances (resectoscopic only)
Bleeding
Injury to the cervix and vagina
Uterine perforation with potential damage to surrounding structures
Postprocedural infection
Unintended pregnancy
Malignancy
Pain associated with prior or concomitant tubal ligation

Contraindications

Contraindications

Endometrial ablation should not be performed with recent pregnancy or in the presence of active or recent uterine infection, endometrial malignancy, or hyperplasia.
All of the currently available nonresectoscopic endometrial ablation devices have limitations with respect to the size of the endometrial cavity and the nature and extent of anatomic distortion of the endometrial surface. Consequently, they are not recommended for use in women with endometrial cavities that exceed device limitations. Similar circumstances apply for resectoscopic endometrial ablation as well, but the manual nature of the technique may allow it to be applied to a wider spectrum of endometrial cavity sizes and configurations. Indeed, there is evidence that, at least in experienced and able hands, success rates in uteri greater than 12 gestational weeks in size may be equivalent to that of women with smaller sized uteri. Table 3 in the original guideline document demonstrates parameters such as the current limitations in both minimum- and maximum-sounded length and for the type and diameter of submucosal leiomyomata for the nonresectoscopic endometrial ablation devices currently available in the United States.
Additional relevant and absolute contraindications are discussed in the original guideline document.

Qualifying Statements

Qualifying Statements

These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.
The process of informed consent for endometrial ablation should include device- or system-appropriate information regarding risk and a realistic discussion of the potential outcomes of surgery because amenorrhea is not achieved in a substantial number of cases. Furthermore, given the persistence of endometrial tissue, premenopausal patients undergoing endometrial ablation should be counseled to use appropriate contraception.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Foreign Language Translations

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2007 May (reaffirmed 2012)

Guideline Developer(s)

American College of Obstetricians and Gynecologists - Medical Specialty Society

Source(s) of Funding

American College of Obstetricians and Gynecologists (ACOG)

Guideline Committee

American College of Obstetricians and Gynecologists (ACOG) Committee on Practice Bulletins-Gynecology

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

The American College of Obstetricians and Gynecologists (ACOG) reaffirmed the currency of this guideline in 2012.

Guideline Availability

Electronic copies: None available

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 933104, Atlanta, GA 31193-3104; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

Availability of Companion Documents

Proposed performance measures are included in the original guideline document.

Patient Resources

The following is available:

- Endometrial ablation. Atlanta (GA): American College of Obstetricians and Gynecologists (ACOG); 2000.

Electronic copies: Available from the American College of Obstetricians and Gynecologists (ACOG) Web site. Copies are also available in Spanish.

Print copies: Available for purchase from the American College of Obstetricians and Gynecologists (ACOG) Distribution Center, PO Box 933104, Atlanta, GA 31193-3104; telephone, 800-762-2264, ext. 192; e-mail: sales@acog.org. The ACOG Bookstore is available online at the ACOG Web site.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on October 5, 2007. The information was verified by the guideline developer on December 3, 2007. The currency of the guideline was reaffirmed by the developer in 2010 and this summary was updated by ECRI Institute on November 15, 2012.

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